PAPERS AND ORIGINALS

McIlroy was here. Or was he?

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British Medical Journal, 1979, **1**, 973-975

It is now over a year since we last heard of Mr McIlroy, and we must presume him dead. With him has passed an era. His brilliant career spanned the entire life of our National Health Service, and it is improbable that we shall ever see the like of him again. In his day he baffled, entertained, fooled, and infuriated the medical and nursing staff of many hospitals. Numerous neurologists must have made his acquaintance, and many physicians from overseas may remember him from difficult hours spent in his company in various British casualty departments. How much Mr McIlroy cost the health services both here and in Eire will remain a matter for conjecture. The sum must run into six, possibly seven figures.

Case history

Stewart McIlroy may have been born in County Donegal in 1915. His early life was uneventful. In 1944 he was admitted several times to the City Hospital, Belfast, with a left-knee injury that failed to heal. In 1947 "Convict McIlroy" was transferred from HM Prison, Belfast, to Purdysburn Mental Hospital, where he spent five years before beginning his peregrinations. London attracted him. In 1954 Charing Cross Hospital admitted him with a left pneumothorax, sustained (so he claimed) during the reduction of a dislocated shoulder under local anaesthesia at another London teaching hospital. Later that year neurological symptoms made their appearance. These were dramatic, consisting of recurrent episodes of headache, photophobia, neck stiffness, and left hemiplegia. Subarachnoid haemorrhage was repeatedly diagnosed but never confirmed, numerous lumbar punctures yielding clear fluid. Surprisingly, many carotid angiograms were performed, all of them proving normal. Palpation of the skull, on the rare occasions it was carried out, showed the presence of burr-holes. He often demanded large doses of analgesics, and was referred for psychiatric treatment more than once during the next seven years. In this period he seemed to have developed neurological signs suggestive (to some observers) of syringomyelia. Others thought he had a chronic neuropathy with functional sensory loss over the trunk. In 1961, after several episodes of dysphagia, dysphonia, and "acute respiratory failure" (for which emergency tracheotomy was performed), he acquired a permanent tracheostomy, we think in Doncaster.

In 1965 he suffered his first attack of severe abdominal pain. This symptom was to lead to many further hospital admissions. Dozens of barium swallows, meals, and enemas (and at least four laparotomies) failed to disclose a cause for his pain. His scarred abdomen, meanwhile, remained a monument to current investigative enthusiasms, if not to modern powers of discrimination. Under the strain of continued ill health, and by now with an expanding experience of hospital practice, he began to complain of chest pain. This was intermittently diagnosed as angina and worsened progressively. Recurrent chest pain, with or without recurrent episodes of hemiparesis or recurrent acute abdomen or both, led to many further emergency admissions. In 1975, after an admission for chest pain, he developed acute retention of urine. A transurethral prostatectomy was performed.

In 1976 he was admitted to the City Hospital, Belfast—an old favourite—because he had fallen and fractured his right femur. Pinning proved unsuccessful, and later he underwent total hip replacement in London, at St Mary's Hospital, Praed Street. But we are now near the end of our story, for after a few more admissions to various hospitals he made a brief appearance at the Belfast City Hospital, and then disappeared.

Diagnosis

As most readers will have guessed (and many more will know) many of Mr McIlroy's symptoms were fraudulent. The bare bones of the case described do scant justice to his skill and success as a peregrinating patient. All of his acute symptoms and signs were faked, with the exception of his fractured femur and the possible exception of his retention of urine. He had, of course, Munchausen's syndrome. Our persistent inquiries, now spreading over several years, have shown that since 1944 he had been a patient in at least 68 hospitals. We have documented 207 admissions, and there is strong circumstantial evidence for at least another ten. This makes him the longest followed-up patient with Munchausen's syndrome ever recorded. It was at least a year after we began our researches that we discovered that his story had been reported in 1960,[1] but, hardly surprisingly, that interesting account is very incomplete. The report

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clearly shows, however, how McIlroy would sometimes help the doctors find the "relevant" physical signs they were seeking. A history taken in 1960 suggested that he had served in the armed Forces, but subsequent checking shows this to be false. Another hospital record led us to believe that he had been in the RAF, until we discovered that two sets of notes had been combined. The genuine ex-serviceman had died several years before.

We don't know McIlroy's real name and age for certain. His relatives, or so he was fond of recounting, had all met violent deaths at the hands of Republican "bombers and gunmen." This discourages us from seeking to confirm which of his 22 surnames and eight Christian names (table I) were genuine. His sister, we might add, "died" at least three different deaths, on seven different occasions. Whenever afflicted with his recurrent aphonia he would write out his history. Practice makes perfect, and he had refined this to a great art. His symptoms would at first be described separately. Latterly, as one set approached the point of exposure, he would switch to another. When a showdown seemed imminent he would depart with speed, his hemiplegic or paraplegic disabilities miraculously receding. In all, he discharged himself on 133 occasions.

TABLE I—*Surnames and Christian names used by McIlroy in 207 documented admissions. On four occasions his first name was not recorded*

Surname	Times used	First name	Times used
McIlroy	100	William	113
Scott	31	Stewart	58
Jones	15	Thomas	13
Swain	13	Patrick	7
Smith	11	Stuart	6
Wright	9	Samuel	4
Stewart	5	David	1
McElroy	4	John	1
McKilroy	3		
Reid	2		
Swaine	2		
Wallace	2		
Bell	1		
Darragh	1		
McAvoy	1		
McNamara	1		
McVoy	1		
Read	1		
Spence	1		
Stafford	1		
Swayne	1		
Williams	1		

As befits someone with such a wide hospital experience—and who had been "taught on" so many times—McIlroy had acquired a remarkable grasp of medical terminology: so much so, that we suggest that in addition to Asher's "laparotomophilia migrans" he suffered from "neurologica sophistica." His success owed much to his minimal signs of organic neurological disorder, with slight wasting of the intrinsic musculature of the left hand, areflexia of the arms, and dissociated suspended sensory loss over the upper trunk and arms.

We know that McIlroy spent well over ten of the last 34 years in hospitals. Probably during the remaining two decades he had similar domiciles: we just don't have the records. But quite apart from bed and board, he cost the taxpayer dear in investigations and operative procedures. There was always evidence of recent venepuncture, and his numerous scars bore witness to laparotomies and orthopaedic procedures, the details of which are unknown to us. In 1965, after admission to the City Hospital, Belfast, because of difficulty managing his gastrostomy tube, laparotomy showed an enteroanastomosis between two jejunal loops, and that the "gastrostomy" was in fact a jejunostomy. His medical career antedated the widespread use of CAT scanning. He therefore underwent at least 48 lumbar punctures and three air encephalograms, not to mention myelography. Radiographs of his skull had shown burrholes since the early stages of his career. The number of ordinary *x*-ray examinations and blood tests must run into hundreds if not thousands. His survival story bears testimony to the resilience of the human frame and to the relative safety of our hospitals.

Table II lists Mr McIlroy's physical signs. Table III enumerates the hospitals he attended and the minimum number of times he obtained admission to each. We should be pleased to

TABLE II—*McIlroy's physical signs recorded*

Kyphoscoliosis
Clawed toes
Absent pain and temperature sensation over both sides of face, sparing nose
Left palatal weakness
Permanent tracheostomy (with silver speaking-tube)
Weakness and wasting in intrinsic muscles of left hand
Areflexia in both arms
Scars over totally flail left shoulder joint
Absent right index finger
Bilateral pain and temperature loss from C2 to T6
Apparent total anaesthesia in left leg (with sacral sparing)
Variably (? voluntarily) extensor left plantar response
Cutaneous changes over nape of neck suggestive of previous radiotherapy
Deep puckered scar over lower left thigh
Numerous abdominal scars
X-ray findings: right parietal burrholes; absent head of left humerus

TABLE III—*League table of hospitals attended by McIlroy and numbers of times he obtained admission*

	No of admissions
Northern Ireland:	
City Hospital, Belfast	22
Royal Victoria Hospital, Belfast	17
Purdysburn Hospital	6*
Musgrave Park Hospital	5
Roe Valley Hospital, Limavady	4
Bambridge Hospital, County Down	1
Waveney Hospital, Ballymena	1
Route Hospital, Ballymoney	1
Eire:	
Adelaide Hospital, Dublin	5
St Brendan's Hospital, Dublin	5
Jervis St Hospital, Dublin	4
St Laurence Hospital, Dublin	2
Mater Misericordiae Hospital, Dublin	1
St Vincent's Hospital, Dublin	1
District Hospital, Killarney	1†
Scotland:	
Southern General Hospital, Glasgow	1
Edinburgh Royal Infirmary	3
Glasgow Royal Infirmary	6
Eastern District Hospital, Glasgow	1
Lanark Hospital	1
Western General, Edinburgh	1
Aberdeen General Hospital	1
Scotland (Cont)	
Kilmarnock Infirmary	1
Wales:	
Lansdowne Hospital, Cardiff	1
Royal Alexandra Hospital, Rhyl	1
England:	
Whittington (St Mary's), London	9
St Bartholomew's Hospital, London	9‡
Queen Mary's Hospital, Sidcup	8
The Middlesex Hospital, London	7
University College Hospital, London	7
St Mary's Hospital, London W9	6
St Mary's Hospital, London W2	5
Guy's Hospital, London	6§
Royal Hants County Hospital, Winchester	5
The London Hospital	4
Hammersmith Hospital, London	4‖
St George's Hospital, London	4
St Andrew's Hospital, London E3	3
St Giles's Hospital, London SE5	3
St Mary Abbott's Hospital, London W8	3
Mount Vernon Hospital, Northwood	3
Radcliffe Infirmary, Oxford	3
Atkinson Morley's Hospital, Wimbledon	2
Friern Hospital, London	2
England (Cont)	
Lambeth Hospital, London	2
Long Grove Hospital, Epsom	2
Royal Free Hospital, London	2
Addenbrooke's Hospital, Cambridge	1
Basingstoke Hospital	1
Burslem, Hayward and Tunstall Hospital	1
Charing Cross Hospital, London	1
Doncaster Royal Infirmary	1¶
Dudley Road Hospital, Birmingham	1
Edgware General Hospital	1
Hope Hospital, Salford	1
Horton Hospital, Epsom	1
King's College Hospital, London	1
Kingston Hospital, Surrey	1
The Maudsley Hospital, London SE5	1
Mile End Road Hospital, London	1
National Hospital for Nervous Diseases	1
Queen Mary's Hospital, Roehampton	1
Royal Southern Hospital, Liverpool	1**
Royal Victoria Hospital, Newcastle	1
St Charles's Hospital, London W10	1
St Francis Hospital, Dulwich	1††
St Helier Hospital, Carshalton	1
St Pancras Hospital, London	1
Stoke Mandeville, Aylesbury	1
West London Hospital	1

*Readmitted while notes out on loan, in 1975.
†Raspe, Baron von Munchausen's biographer, buried here.
‡1955: Said he was told he would "die on the end of the needle" during next lumbar puncture. Didn't.
§Admitted wearing King's College Hospital pyjamas!
‖1975: Simultaneous arrival on ward of two *x*-ray porters, sent to fetch patients with different names but same case number.
¶Permanent tracheostomy 1961: arrived Doncaster within hours of leaving St Mary's, London, where his last tracheostomy had been closed.
**Notes reported eaten by rats in condemned storeroom.
††Transferred from police station to which he had reported, on arrival from Glasgow, claiming to have committed a murder.

send anyone the full list, which is too long to reproduce here. The copies of discharge summaries and notes in our possession total four shelf-inches, A4 size.

We hope this obituary is premature. It was once said that old patients with Munchausen's syndrome were like old soldiers: they never died but just faded away. Stewart McIlroy taught many lessons to those who were deceived, not least being the lesson that we are not always the astute physicians we should like to believe.

Postscript

Munchausen's syndrome has been much discussed since Asher first described it.[2] The difficulty of arranging psychiatric treatment is well known: the patients will not stay long voluntarily, and it is usually impossible to justify detention under the sections of the Mental Health Act.[3] The concept of a general register has been rejected as unethical, and the black book kept in casualty departments is circumvented if (*a*) a new name is used and (*b*) the symptoms are convincing—and they usually are, especially if there is a genuine underlying medical condition.[4]

Our thanks are due to the many physicians and medical records staff who replied to our requests for information during the past four years.

References

1 Manning, G C, *Medical Press*, 1960, **243**, 232.
2 Asher, R, *Lancet*, 1951, **1**, 339.
3 Blackwell, P, *Guy's Hospital Reports*, 1965, **114**, 257.
4 Unfug, H V, *Journal of the American Medical Association*, 1977, **238**, 2265.

(*Accepted 1 March 1979*)

Neural-tube defects: importance of a history of abortion in aetiology

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British Medical Journal, 1979, **1**, 975-976

Summary and conclusions

The overall incidence of anencephaly and spina bifida (ASB) in 69 056 pregnancies was 4·7/1000 births. ASB was more common (8·4/1000 births) among children of mothers who had had two or more abortions, but the increased risk was confined to spina bifida. A history of abortion was more common in older women and women of higher parity, but this was not matched by a similar increase in the incidence of ASB. The incidence of ASB was related to social class, but the prevalence of previous abortions was similar in all classes.

The results suggest that expectant mothers with a history of two or more abortions have an increased risk of producing a child with spina bifida. The abortions are considered to be a manifestation of previous abnormal conceptions rather than the primary cause.

Introduction

Clarke *et al*[1] suggested that trophoblastic "rest" material remaining after a miscarriage may be associated with the subsequent delivery of a child with anencephaly or spina bifida (ASB), postulating that the rest material interfered with normal formation of the neural tube during early fetal life. This suggestion was confirmed by Gardiner *et al*,[2] who found that patients whose previous conception had ended in spontaneous abortion had a significantly higher incidence of infants with congenital malformation than patients whose previous conception had resulted in a normal live-born child. Their study, however, was limited by small numbers. I have tested the rest hypothesis by looking at factors that influence the incidence of both ASB and abortions in an overall population.

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Patients and methods

Records were obtained from the Cardiff Births Survey (CBS) of all mothers who had given birth in Cardiff hospitals during 1965-76. An association was sought between ASB and a history of abortion. Although the CBS does not give detailed information on all immediate past conceptions or distinguish spontaneous from therapeutic abortion, this is not critical in testing the rest hypothesis, which postulates that it is the presence of trophoblastic material that is relevant, not the type of abortion. Further data linked the association between a history of abortion and ASB and, respectively, social class, maternal age, and parity—all three factors known to be causally related to neural-tube defects.[3 4]

Results

A total of 69 056 mothers delivered 70 871 infants. Of these, 331 had ASB (146 anencephaly, and 185 spina bifida), an overall incidence of 4·7/1000 births. The following analysis is of singleton births only.

Table I shows the incidences of ASB according to the past history of abortion. Of all 321 infants with ASB, 248 (77·3%) were born to mothers who had never had an abortion. Forty-eight mothers (15·0%) had had one abortion, and 25 (7·8%) two or more. The increased incidence of ASB after one abortion was not significant, but the increased incidence of spina bifida after two or more abortions was highly significant ($\chi^2 = 18{\cdot}5$; $P < 0{\cdot}001$). Table II shows the incidences of ASB in primiparous patients whose immediately previous conceptions ended in abortion. Again there was a highly significant increase in the incidence of spina bifida ($\chi^2 = 10{\cdot}2$; $P < 0{\cdot}001$) after two or more abortions. There was no association between a history of abortion and the incidence of anencephaly.

The incidence of ASB was highest in social classes IV and V (table III). The prevalence of a history of abortion, however, was similar in all classes. Table IV shows that ASB occurred most often